II. Or, all other ICFs/MR (nonstate) (class 2)

LEVELS OF CARE:

The level of functioning is calculated by screening all ICF/MR clients in Kansas using the Basic Assessment and Service Information System Screening (BASIS), which assesses clients on three (3) indices: adaptive functioning, maladaptive behavior, and health needs. Facility converted scores are obtained by performing the following calculations:

1. Each index score is divided by the highest score obtained in Kansas in a given year for the corresponding index.
2. The resulting scores for each index are added together and averaged.
3. The resulting number is multiplied by 100. (Thus, the maximum possible converted score is 300).

Using the above methodology, five (5) levels of care are identified using the following converted BASIS scores:

LEVELS	CONVERTED BASIS SCORE
Level I	150 - 300
Level II	125 - 149.99
Level III	100 - 124.99
Level IV	75 - 99.99
Level V	50 - 74.99

DIRECT SERVICE LIMITS:

Direct service limits are based on both facility size (divided into three (3) groups based on number of beds) and levels of care, as follows:

DIRECT SERVICE LIMITS

	LEVEL OF CARE				
FACILITY SIZE	Level I	Level II	Level III	Level IV	Level V
A: +16 beds	$120.00	$115.25	$98.66	$82.39	$59.85
B: 9-16 beds	$135.00	$129.59	$120.00	$106.00	$69.54
C: 4-8 beds	$163.00	$153.00	$129.05	$99.91	$78.55

ADMINISTRATIVE LIMITS:

Administrative per diem limits are based on facility size using the same three (3) facility size groupings referenced above as follows:

ADMINISTRATIVE LIMITS

FACILITY SIZE	ADMINISTRATIVE LIMIT
A: +16 beds	$9.50
B: 9-16 beds	$17.50
C: 4-8 beds	$25.00

OWNERSHIP ALLOWANCE:

Ownership allowance is established by a property fee system, which is a continuation of the system used previously. The per diem reimbursement for facility ownership is based on the historic cost of each facility. The fee has been calculated by analyzing all facility costs, arranging them from high to low, placing them into five groups, then adding "value factors." The value factor was intended to reward those providers with low ownership costs -- mortgage interest, rent/lease expense, amortization, and depreciation. The value factor calculations for ICFs/MR are the same as used in the Nursing Facility program (see Medicaid State Plan transmittal #87-43, effective 10-01-87, approved 02-05-88).

The calculation methodology for the value factor follows:

1) Property Allowance Calculation

The four line items of ownership cost -- mortgage interest, rent/lease expense, amortization, and depreciation -- were added together then divided by number of client days to arrive at the ownership cost per client day for each provider.

2) Value Factor Calculation

For all providers, the property allowances were arrayed base on facility size and percentiles were established. These percentiles became the basis for establishing the property value factor. Five (5) different percentile groupings were developed from each array as follows:

Percentile Grouping	Percentile Ranking	Add-on Percentage
1	Zero through 25th percentile	45%
2	26th through 50th percentile	15%
3	51st through 75th percentile	7.5%
4	76th through 85th percentile	5%
5	86th through 100th percentile	0

Once the percentile groups were established, a weighted average property allowance was calculated for each group. This average property allowance was then multiplied by the add-on percentage to arrive at the property values factor for each group. This add-on percentage is inversely related to the percentile ranking. That is, the lower the percentile ranking, the higher the add-on percentage. The property value factor for each percentile group was then assigned to each provider within that group. See below for the specific values.

GROUP	PERCENTILE FROM	PERCENTILE TO	AMOUNT FROM	AMOUNT TO	AVERAGE ALLOW.	PERCENT	VALUE FACTOR
		ICF/MENTALLY RETARDED - LARGE FACILITIES					
5	86	100	$6.26	+	$6.82	-0-	-0-
4	76	85	$5.79	$6.25	$6.25	5.0	.31
3	51	75	$3.73	$5.78	$5.11	7.5	.38
2	26	50	$3.17	$3.72	$3.61	15.0	.54
1	0	25	-0-	$3.16	$2.28	45.01	.03
		ICF MENTALLY RETARDED - SMALL & MEDIUM FACILITIES (ie: 4-16 beds)					
5	86	100	$7.88	+	$14.36	-0-	-0-
4	76	85	$7.80	$7.87	$ 7.87	5.0	.39
3	51	75	$5.43	$7.79	$ 6.46	7.5	.48
2	25	50	$5.12	$5.42	$ 5.29	15.0	.79
1	0	25	$2.88	$5.11	$ 3.87	45.01	.74

Providers will continue with the fee as previously calculated. New facilities have the Ownership Allowance developed from their first actual cost report using the above table to determine the "value factor".

Plant operating costs are reimbursed at actual allowable cost to operate the facility.

INFLATION:

Medicaid rates for Kansas Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) are determined utilizing a prospective, facility-specific rate setting system. Generally, each provider files an historical cost report coincidental with their fiscal year end. An adjustment for inflation is then added to these historical costs. The inflation adjusted costs are then subjected to cost center limits.

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In understanding the rate setting system, it is helpful to review three relevant time periods:

I. Cost reporting period - The provider's fiscal year and period of cost report

II. Limitation period - The period of time a given set of limitations (e.g., cost center limits) are in effect. This period begins each October 1 and continues through the following September 30.

III. Payment period - The period of time a given Medicaid rate is in effect. This is the period between rate effective dates.

An example may help clarify these periods. Assume a provider has a fiscal year ending 12/31/91. They would file a cost report covering the period of 1/1/91 through 12/31/91. Assume this cost report was filed by 3/31/92 such that a rate effective date of 6/1/92 was assigned. This date is the provider's Schedule A rate effective date (RED). The Schedule A RED determines when the Medicaid rate based on the newly filed cost report becomes effective. The payment period would then be from 6/1/92 through 9/30/92, or the remainder of the current limitation period. Effective 10/1/92 the established limits are reevaluated and adjusted if necessary. Historic and estimated inflation is added to the most recent cost report for each facility. This amount is compared to the limit and a new rate is established, which is the lower of the actual costs plus inflation or the limit. The October 1 date is the Schedule A-1 rate effective date.

This new rate is based on the most recently filed cost report (i.e.,12/31/91) and is due to entering a new limitation period. This means that, generally, there are two payment periods in each year - one beginning a few months after a provider's fiscal year end, and another beginning the following October 1. A time line illustration of these periods appears below.

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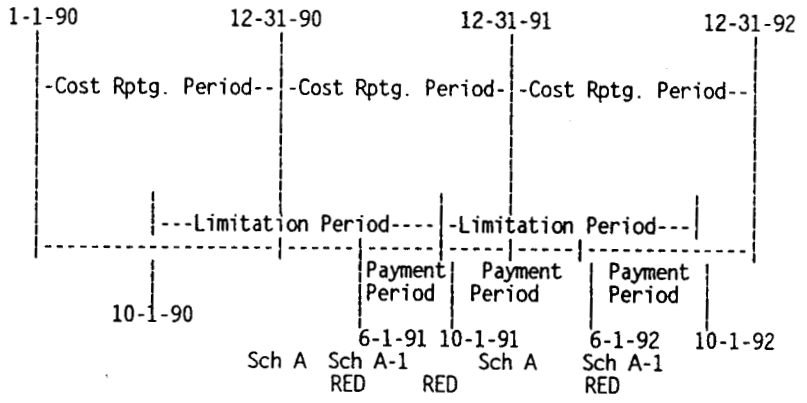
Illustration of Rate Setting Periods



Inflation Factors

The system of applying inflation factors is designed to be equitable to any provider, regardless of their particular fiscal year and cost report filing dates, in setting cost center limitations and determining payment rates. Cost center limitations are determined each year at the beginning of the new limitation period and new reimbursement rates are established at least twice each year. Once, based on the provider's new cost reports, and again at the beginning of each limitation period. To accomplish this, four inflation tables are needed - two historical and two estimated. The following matrix helps to clarify how these four inflation tables are used.

	Historical Inflation	**Estimated Inflation**
Schedule "A-1" To set Oct. 1	Adjusts from mid-point of cost report period to latest CPI (generally August).	Adjusts from latest CPI to midpoint of the payment period.
Schedule "A" set new Cost Report Rates	Adjusts from mid-point of cost period to end of cost period.	Adjusts from end of cost period to midpoint of payment period.

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The basic philosophy of the inflationary adjustment is to utilize factors that will adjust data from the middle of the cost reporting period of each provider to the middle of the payment period. The purpose for using midpoints for these respective periods is twofold. First, it eliminates the need to recalculate rates for each provider on a monthly basis. And second, it is felt that these two points are the most representative points in time to approximate the price level for the entire cost period or payment period.

The historical inflation factors are based on the Consumer Price Index (C.P.I.) developed by the Bureau of Labor Statistics of the U.S. Department of Labor. The base years of the present index are 1982-84. There are no adjustments made to any of the components included in the present index. The purpose for which the index will be used determines how the factor is computed. In conjunction with the table above, the factor for a new rate based on a new cost report would be the percent of increase in the C.P.I. from the midpoint of the provider's cost period to the end of the cost period. The historical inflation factor is a ratio of the C.P.I. at different points in time. Should this ratio of the C.P.I. result in a historical inflation factor less than zero, the historical inflation factor will equal zero.

The annual percentage rate for estimated inflation is a projection based on economic forecasts and predictions of reputable and prominent national publications. This annual percentage estimate is used consistently throughout the limitation period.

The inflation factors are applied to all costs except the following:

Allowable Costs:	Exempt from Historical	Exempt from Estimated
1. Salaries:		
Administrator	Yes	Yes
Co-Administrator	Yes	Yes
All Other Non Owner Employees	Yes	No
2. Payroll Taxes	Yes	No
3. Owner's Compensation	Yes	Yes
4. Interest Expense other than Real Estate Mortgage	Yes	Yes
5. Real Estate Taxes	Yes	Yes
6. Personal Property Taxes	Yes	Yes

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LIMIT ADJUSTMENT

Annually, prior to October 1, which is the anniversary date to this rate setting methodology, the CPA firm that processes the ICF/MR rates develops an analysis of the rates and costs of all ICFs/MR in Kansas. The rates paid are compared with the actual allowable costs incurred by the facilities.

After this is done the total amount of actual allowable costs for each facility will be compared to the amount to be reimbursed for these facilities under the current limits. The total number of facilities which are determined to be reimbursed at least 95% of the actual allowable costs is then divided by the total number of facilities.

When this analysis indicates that fewer than 75% of the facilities are reimbursed less than 95% of their costs, the limits will be increased to allow this threshold to be met. At the same time provider cost reports are adjusted for inflation. The historical inflation factor is based on the Consumer Price Index (C.P.I.) developed by the Bureau of Labor Statistics of the U.S. Department of Labor. It is also used to establish the basic inflation for rate setting and will be utilized to adjust the limits, when necessary.

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INSTRUCTIONS FOR COMPLETING FINANCIAL REPORTS FOR STATE ICF-MR FACILITIES

PURPOSE

The purpose of this report is to obtain the client-related costs incurred by State ICF's-MR in providing services according to applicable state and federal laws, regulations, and quality and safety standards. The regulations governing the completion of this report and ICF-MR reimbursement can be found in the Kansas Administrative Regulations, Chapter 30, Part 10, Sections 200-226 effective June 1, 1991.

1. One blank Financial Report for State ICF-MR Facilities is sent by Mental Health and Retardation Services (MH&RS) to each state ICF-MR facility in the Medicaid/Medikan Program before the end of the facility's reporting period.

2. Send two copies of the completed Financial Report for State ICF-MR Facilities to the following address:

   Mental Health & Retardation Services
   Department of Social & Rehabilitation Services
   915 SW Harrison
   Docking State Office Building, 5th Floor
   Topeka, KS 66612

   Attention: Administrator, ICF-MR Reimbursement

3. All inquires on completion of these forms should be directed to the Administrator, ICF-MR Reimbursement, MH&RS, at (913) 296-3476.

GENERAL

1. COMPLETE THE FORMS ACCURATELY AND LEGIBLY. ANY REPORT THAT IS INCOMPLETE OR IS NOT LEGIBLE WILL BE PROMPTLY RETURNED TO THE PROVIDER. THIS MAY POSTPONE THE RATE EFFECTIVE DATE AND RESULT IN ADDITIONAL PENALTIES FOR LATE FILINGS. KAR 30-10-213 AND 214.

2. ALL TOTALS MUST BE ROUNDED TO THE NEAREST DOLLAR.

3. DO NOT ADD LINES TO THE FORMS. Use "OTHER" lines for patient-related expenses not designated on the Expense Statement, Schedule A.

4. DO NOT CROSS OUT OR RETITLE LINES ON THE FORMS.

5. USE THE ACCRUAL METHOD OF ACCOUNTING IN REPORTING FINANCIAL DATA. Revenues are reported in the period when they are earned, not when they are received, and expenses are reported in the period in which they are incurred, not when they are paid.

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6. ALL COST REPORTS, HISTORICAL OR PROJECTED, MUST BE FOR A PERIOD OF 12 CONSECUTIVE MONTHS. KAR 30-10-213.

7. ALL COST REPORTS MUST ME FILED BY THE LAST DAY OF THE THIRD MONTH FOLLOWING THE END OF THE REPORTING PERIOD (FISCAL YEAR END OR PROJECTION). KAR 30-10-213. The provider may request a 30-day extension of the due date by submitting the request in writing to the address in the submittal instructions within the time period allowed for filing the original cost report. The extension will be granted if the agency determines that the provider has shown good cause. NOTE: IF A COST REPORT IS FILED AFTER THE DUE DATE WITHOUT AN APPROVED TIME EXTENSION, THE PROVIDER IS SUBJECT TO THE PENALTIES SPECIFIED IN KAR 30-10-213.

8. EACH STATE ICF-MR SHALL MAINTAIN ADEQUATE ACCOUNTING AND/OR STATISTICAL RECORDS. Inadequate recordkeeping is cause for suspension of payments or reduction to the lowest rate(s) for the level(s) of care provided. KAR 30-10-210.

9. REIMBURSEMENT RATES (PER DIEM) FOR STATE ICF-MR. The per diem rate of reimbursement for these facilities is based on the reported costs and client days as adjusted by a desk review of the cost report. An additional factor may be included in determining the prospective rates to account for expected changes in either the costs or resident days during the subsequent fiscal year. Each cost report is also subject to a field audit to arrive at a final settlement for the period the per diem rate was based on the audit cost report.

10. KANSAS ADMINISTRATIVE REGULATIONS. Copies of the regulations governing State ICF-MR reimbursement may be obtained from the address given in the submittal instructions. NOTE: SINCE THE REGULATIONS MAY BE CHANGED ANNUALLY, THE PREPARER OF THE COST REPORT SHOULD CAREFULLY REVIEW THE MOST RECENT VERSION PRIOR TO COMPLETING THE FORM.

COST REPORT INSTRUCTIONS

COVER PAGE

A) Provider Identification

LINES 11-19 Complete these lines as indicated on the report form.

LINES 21 THROUGH 25: Check Only One Box.

LINE 21. Check if the cost data is for the normal fiscal year of the provider and does not include any portion of a projection period.

LINE 22. Applies to projected cost reports for new providers that are not occupying a newly constructed facility.

LINE 23. Applies only to projected cost reports related to newly constructed facilities. If a provider occupies a newly constructed facility they should check this box. Providers that have increased total beds available through new construction to an existing facility by 10% or more may file a projected cost report and should check this box. KAR 30-10-214.

LINE 24. Applies only to providers filing historical cost reports for the same 12 month period as thur projection year.

LINE 25. Applies to providers in the process of converting from the projection period to their normal fiscal year and the report period includes a portion of the projection period.

LINE 26 THROUGH 32. Check only one box. Check the type of business organization which most accurately describers your facility or explain on line 32.

B) Facility Beds:

LINES 43 THROUGH 45. Enter the number of beds available for each category listed. If a change in the number of beds has occurred during the reporting period, show the increase (of decrease) and the date of the change. Total the categories on line 45.

LINE 46. TOTAL BED DAYS AVAILABLE If the number of beds available throughout the year has not changed, the total number of bed days is computed by multiplying the number of beds times 365 (366 in leap years). If the number of beds changed during the period, compute as shown in the example below.

Assume a home of 20 beds was increased on July 1 to 25 beds, the number of bed days for the period would be determined as follows:

January 1 to June 30 _ _ 181 days x 20 beds =	3,620 bed days
July 1 to December 31 _ _ 184 days x 25 beds =	4,600 bed days
	8,220 bed days for period